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EPI-SODE

EPIDEMIOLOGIC **S**URVEILLANCE **O**F COMMUNICABLE **D**ISEAS**E**

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New Health Officer - Dr. Justin Denny

A very warm greeting to each of you as I attempt to fill the very large shoes left by Dr. Karen Steingart. Thus far I have been so openly and warmly welcomed into this community, and am thrilled by an opportunity to work closely with all of you on matters of public health significance. I come to Clark County after training in public health and preventive medicine at Oregon Health and Science University (OHSU). I have worked in Wasco, Sherman and Columbia counties as their health officer and have had clinical experience in family and emergency medicine in both rural Oregon and the Portland metro area. I continue to teach public health concepts to residents in the preventive medicine residency and matters of global health to undergraduates at Portland State University. My priorities as new health officer include becoming acquainted with all community medical providers, bringing preventive and public health perspectives to community partners by being more visible and accessible to them, addressing the obesity trends in Clark County via examining the built environment and opportunities for residents to exercise, and assisting with the health care access needs of the uninsured. Should you ever be in interest of a guest speaker to bring community public health topics into your practice, please hink of me as I would be delighted by an opportunity to discuss these issues and with you and your colleagues.

Influenza (Avian Flu)

While our flu season thus far has been memorable for the vaccine shortage and the challenges presented in vaccinating our high risk populations, talk has shifted to the possible emergence of a 'killer flu' variety from southeast asia, 'Avian flu.' As of February 17th, 2005, this highly pathogenic avian influenza A (H5N1) continues to cause small outbreaks in Vietnam, Thailand and Cambodia where 42 of 55 cases have died. While no sustained person to person spread has been documented, we have learned of resistance of this organism to amantadine and rimantadine, the fact that it is becoming endemic to birds in the region, and that ducks infected with H5N1 are shedding more virus for longer periods of time without any symptoms of illness. I will continue to update you on these troubling trends, and most appreciate all of your help with allocating vaccine supply to those at high risk.

Meningitis

Three early cases of *neisseria meningitidis* within one week kept our epi team hopping as we attempted to find common exposures between the cases while treating all direct contacts. Luckily, as a result of the prompt and excellent medical care received, all three cases survived and have been discharged from the hospital. No evidence was found to support a common source and no secondary cases resulted from exposure to these cases. These sporadic cases of *n.meningitidis* were all serogroup B, which is not vaccine preventable and the most predominate sub group in the pacific northwest (70%). All cases had high fevers with either the characteristic rash (non blanching and purpuric), headaches, or retractable vomiting which prompted their parents to seek medical care early in the course of their illness.

Lymphogranuloma Venerum

Recently there has been a resurgence of lymphogranuloma venereum (LGV) caused by *Chlamydia trachomatis* serovars L1, L2 and L3 among men who have sex with men (MSM) in the Netherlands. Cases of LGV were reported in the San Francisco Bay area in 2004, and contacts have been identified in the Portland metro area. If a person at risk for LGV (MSM exposed to persons from Europe or San Francisco and MSM with symptoms compatible with LGV, e.g., proctitis, proctocolitis, inguinal/femoral lymphadenopathy), please do the following:

- Notify your local health jurisdiction that you have a suspect case of LGV.
- Collect rectal and serum specimens from the patient (we can send information on how to do this)
- Provide treatment to the suspected case and evaluate sex partners who had contact with the patient within 30 days of the onset of the patient's symptoms. Recommended treatment for LGV is doxycycline 100mg twice a day for 21 days. Alternative treatment is erythromycin base 500 mg orally 4 times a day for 21 days. Sex partners who have symptoms consistent with LGV should be tested in the same manner as the initial patient. Those with no symptoms should be treated with 1 g azithromycin in a single dose or 100 mg doxycycline twice a day for 7 days.

HIV

A three class antiretroviral-resistant strain of the human immunodeficiency virus (3DCR HIV) has recently been diagnosed in a New York City resident who had not previously undergone antiviral drug treatment. Treatment in this situation is much more difficult and this strain is known to shorten the interval between HIV infection and the onset of AIDS (from ten years in a typical case to twenty months or fewer 3DCR HIV). The patient had high risk behavior (MSM with multiple partners, unprotected anal intercourse and crystal methamphetamine use), was diagnosed with HIV in December of 2004, has developed AIDS and is undergoing treatment. This case emphasizes the importance of screening all persons at risk for HIV for the disease and for testing for drug resistance in those who are newly positive.

Disease Reporting Change

On January 11, 2005, the Washington State Board of Health filed an amendment to Washington Administrative Code (WAC) 246-101 that made changes in requirements for the reporting of notifiable conditions. The most significant of these changes is that **Arboviral** (mosquito-, sandfly- or tick-borne) **Diseases**, made notifiable August 3, 2004 by an emergency order of the State Health Officer, have been adopted as permanently notifiable, and replace **Encephalitis, viral** which has been removed from the list of notifiable conditions. Also, **Streptococcus, Group A, Invasive** has been dropped from the list of notifiable conditions. A full report on these and other changes can be found at http://www.doh.wa.gov/notify/list.htm

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